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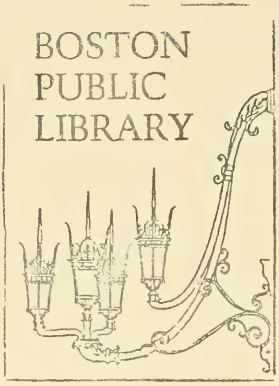
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CHRONIC PROBLEM FAMILIES

by

Edward Stone, M.S.S.W.

June, 1961

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CHRONIC PROBLEM FAMILIES

by

Edward Stone, M.S.S.W.

June, 1961

Consultant: Joan Zilbach, M.D.

ACTION

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BOSTON COMMUNITY DEVELOPMENT

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for several years. Dr. Zilbach has labored diligently with the author, freely sharing of her considerable knowledge and experience in the writing of this paper.

Introduction

This report is designed to provide an understanding of chronic problem families and to analyze the opportunities and difficulties that urban renewal will bring to these families and the city in which they live. There is, unfortunately, little written material of depth available; the literature that served as background for this report is listed in the bibliography.

Chronic problem families are a national concern. They are known by many names: "hard-core", "hard-to-reach", "socially delinquent", "multi-problem" and "chronic problem". These terms accurately reflect the complex and difficult life patterns of these families.

For this report the term "chronic problem" will be used. It appears to describe most aptly the pattern of generationally repetitive, serious problems that occur in the every-day lives of these families--problems that often have a disastrous impact on the family and the community.

1. Description

These are families who are riddled with a multiplicity of problems and who cannot maintain themselves without extensive outside help. Their problems include crime, delinquency, alcoholism, promiscuity, neglect or intermittent placement of children, and prolonged stays in medical and mental hospitals.

They have a long history of difficulties in many spheres of basic family functioning: employment, housing, food, religion, schooling, physical and emotional health.

They appear to have little or no core of inner self-sufficiency. Their extremely poor social adjustment is coupled with attitudes that are consistently hostile, suspicious and resistive.

These families have many contacts with countless social agencies over a long period of time. They often make excessive demands for aid and create confusion and a sense of intense frustration in those who wish to help them. There are frequent and repeated failures to use this aid constructively, which result in seemingly unending and unsuccessful attempts to control or ameliorate their difficulties.

Chronic problem families fail to respond with improvement when they are offered the usual kinds of services - social agency, hospital, court, clinic, church, etc. They may come for help, but then tend to defeat efforts at follow-through either by breaking off contact with the service facility or by provoking the service facility into breaking off contact with them.

These families are in marked contrast to those who may from time to time exhibit a multiplicity of problems but can accept the usual kinds of help. Unlike the chronic problem families, this latter group responds with sufficient inner resources which permits them to return to a reasonable state of self-sufficiency and equilibrium.

Chronic problem families are often completely isolated from neighbors or constantly in open conflict with neighbors and the community at large.

They are persistently in difficulty with the law and other sources of authority, involving, for example, school adjustment counselors and probation and parole officers in activities which usually fail to achieve marked rehabilitation.

They are in constant financial difficulty and often make unrealistic purchases while failing to pay for the basic necessities of life.

They are in intermittent or prolonged contact with public welfare agencies and often disguise sources of income from welfare agents.

They move often, sometimes several times in one year, rarely bettering themselves. They are constantly in conflict with landlords over failure to pay rent or to keep up housekeeping standards.

2. Attitudes in the General and Professional Community

This description accounts for many attitudes about the chronic problem family which have grown up in the community at large and among the professional and allied groups who work with them.

The negative, provocative behavior of the families wears heavily on neighbors and the local business community and especially on landlords and public housing authorities. Their behavior has the same effect on professional and allied workers. This results in feelings of intense frustration and guilt, particularly among workers whose best efforts at helping these families prove of little avail.

The frustration and guilt turn to anger which is then directed back onto the families and results in the use of retaliatory tactics; 1) the families are negatively stereotyped, 2) agencies either shut off help abruptly or refuse outright to help, 3) the families are either excluded from or driven from neighborhoods, 4) they often face eviction and refusal of further credit at the corner grocery, 5) they are often over-punished in other ways by agencies, e.g. the courts.

Inadvertently, because of the difficulty in working with these families, professional and allied workers turn their greatest efforts in the direction of helping more responsive, less disturbed parents and children. This is out of a natural wish to see improvement and to derive the gratification which comes from this.

Even the most dedicated of service and research personnel come to view the behavior of these families as: 1) attacks upon ordered society, 2) violations of community codes of ethics and morality, 3) rebellion against a better way of life, 4) indicative of a largely irreversible sub-cultural pattern.

In many social agencies and clinics these people are often perceived as "psychopaths" -- "not ready for treatment"--"not properly motivated"--"inaccessible"--"resistive"--"uncooperative".

Some social scientists may describe them as a subcultural group, generally comfortable in their way of life. Efforts to provide rehabilitation are viewed by many social scientists as impositions of middle class standards upon lower class people.

Among landlords and business people many of these families are viewed as "dead-beats". Employers see them often as "scum" to be exploited without feeling. Neighbors talk about staying away from them and revel in gossip about their private and public exploits.

These attitudes have unfortunately been strongly influential in the shaping of programs and methods used to deal with the chronic problem family. They account in part for the fact that the problems remain ever-present, untouched, costly, and seemingly irreversible. These families continue as a blight in the community to mock our best efforts to achieve better familial relationships and healthier neighborhoods.

3. Influence of Behavior and Attitudes on Management, Diagnosis, Treatment, and Rehabilitation

The sum total of the tensions and pressures generated (and counter-generated) around the chronic problem family has seriously impeded: 1) efforts to understand the true nature of their behavior, 2) more comprehensive and enlightened diagnosis, management and treatment of their problems, 3) communication between the families and the community, 4) examination of the practices of agencies dealing with the families to determine if they are properly meeting the real needs.

When these families are viewed in global, undifferentiated terms, they are hardly able to achieve a separate identity as people who have serious, often frightening problems. In their failure to differentiate and individualize chronic problem families and members of these families, the professional community has fallen

back on ideas which are utilized in the diagnosis and treatment of other kinds of families and people. In this respect an imposition has been made. Ideas about human behavior in general have been imposed upon a particular group of people, without recognition that these ideas may not be applicable. If the chronic problem family does not react "properly" to these ideas, then the family is seen to be at fault.

When it is possible to study these families without the intense emotional coloration that usually surrounds the issues, it can be seen that such families need intensive and persistent follow-up by helping agencies in order to accomplish change for the better. This often requires much more active participation by an agency than is usual in other kinds of family problems. It includes making direct offers of service through repeated home-visiting and "reaching-out". Unfortunately, much of this type of service has gone out of vogue under the mistaken notion that services like home-visiting encourage too much "laziness and leaning". Applied indiscriminately to everyone, this notion is valueless. The refusal by many agencies to recognize this need for active services accounts in large measure for the so-called "inaccessibility" of these families.

Many parents in chronic problem families feel worthless; many are pre-occupied with the fear that they are "crazy". Thus, when they are severely criticized by well-intentioned, helping people, this simply confirms their feelings about themselves and serves only to push them deeper into self-destructive activity.

Levels of expectation and goal achievement have often been set up for these families which they can not achieve without intensive help. This often occurs when these families are involved in urban renewal programs. In rehabilitation areas, the expectation is that people will be able to participate in cooperative planning and will assume responsibility for making property improvements. The fact is that chronic problem families often have extreme difficulty with both of these expectations. They are already considered extremely poor risks by landlords. Renewal programs not clearly alerted to such problems will find these families even more wanting.

In the case of relocation into different housing, the assumption is repeatedly made that these families will meet the challenge in a positive, constructive way. Instead of a simple transition to a new home and improved neighborhood, the family produces crisis after crisis. Housing authority personnel and landlords are all too soon caught in the unhappy position of having to evict these families because they have responded in a reverse fashion, often becoming destructive of property and a scourge in the housing development or neighborhood.

Urban redevelopers and social welfare people then express genuine concern that chronic problem families are incapable of perceiving the nature and meaning of urban renewal as part of an American dream, a fulfillment of the wish for a better way of life for all. This can and has become a tragic notion, because of the failure to separate the family's <u>wish</u> to share in the benefits of a better way of life from their <u>inability</u> to do so. There is ample

experience to confirm the thesis that chronic problem families perceive the American dream readily enough, but do not know how to achieve its fulfillment.

There is strong evidence that members of chronic problem families have never experienced the kind of sustained, loving, consistent human relationships that are prerequisites for the development of trust in human interactions. Failing to achieve this basic prerequisite makes it impossible for them to share in any meaningful way in the American dream unless they can first be helped to learn to trust. Unless this is recognized there will continue to be a wide gap between their wish to share in achieving the goals of a reasonable society and their capacity to do so.

In summary, this introduction has stressed the thesis that the provocative, troublesome behavior of chronic problem families has led to community attitudes which have impeded understanding, communication, and efforts to provide effective help. It is hoped that the material which follows will contribute to clearing away some of the confusions surrounding these families and will contribute to the development of more organized, more constructive methods of dealing with their problems.

In the following pages the material has been separated artificially into different ways of viewing and understanding chronic problem families. This is done simply for the sake of clarity in dealing with different factors and perspectives. It must be recognized that in order to understand these families, all factors

must be taken into account and woven together. No single approach is complete or desirable in and of itself.

Psychodynamics

The psychodynamic approach is one avenue to understanding the chronic problem family. Along with approaches which include cultural and environmental considerations, the psychodynamic view can contribute to a more complete understanding and a more solid basis for diagnosis and treatment. The psychodynamic approach provides an opportunity to study the meaning of persistent behavior which tends to defeat the individual's potential, creativity and constructive growth from childhood into adulthood. Psychodynamic understanding materially increases the range of planning treatment programs for families; it may or may not include psychiatric treatment of such.

The treatment of families with a chronic multiplicity of problems requires a broad understanding of the personality and behavior patterns of individual family members. Speculations will be offered as to how individual personality dynamics affect the total family's functioning, but at the present time psychodynamics of family patterns are much less clear.

Classification of Chronic Problem Family Parents

Three characteristic classifications of parents in chronic problem families will be discussed here: 1) Character Disorder, 2) Schizophrenic, 3) Mixed Type. These three groups manifest severe personality disorders sufficiently destructive to account

for the major problems which the families evidence. This section focuses on parents in chronic problem families and their own childhood. Discussion of the effects of this on the present generation of children is included.

The clues which uncovered new areas of exploration of individual personality problems in chronic problem families came to a large extent from research with juvenile delinquents and their families. This research, pioneered by child analyst Irving Kaufman, M.D. and the delinquency research group under N.I.M.H. grants, had a strong psychoanalytic orientation. It was found that: 1) many of the chronic problem families were struggling with problems in juvenile and adult crime, 2) where criminal behavior was not actually a court matter, its aura hung over the families and was a potential threat, 3) many of the parents in chronic problem families acted in much the same ways as parents of juvenile delinquents.

The study which followed this direction has proved to be productive in discerning and understanding the behavior of chronic problem family parents. It is interesting to note that the term "psychopath" is being replaced by the term "character disorder" nationally in clinical circles. The "psychopath" in the past was considered "untreatable". The term "character disorder" indicates response to treatment when the techniques of the treatment are suited to the real needs.

General Description of Parents in Chronic Problem Families

The behavior of parents in chronic problem families is infantile, impulsive and inconsistent. All three terms are reminiscent of

children and implicitly pinoint what is considered to be the core of the problem. The emotional growth of these parents was severely arrested early in their lives.

Investigations into their early life patterns brings out these factors: 1) they suffered unusually severe experiences that stunted their emotional growth, 2) there was little if anything in their environment, at the time they suffered these experiences, to buffer them or to help them through it. There were no reliable parents or parent substitutes on whom they could depend at the time of crisis.

Under the impact of these experiences, they were left extremely vulnerable, emotionally impoverished, and unable to cope with successive crises. This ultimately resulted in their failure to grow into mature adulthood.

The significance of the atmosphere surrounding the childhood of a chronic problem parent, especially during crises, must be taken into account. Otherwise, it becomes difficult or impossible to deal with our own feelings of frustration and anger which these people so often provoke. Most people suffer severe crises in their childhood and yet achieve sufficient maturity to meet the demands of society. What makes the difference in the life of a chronic problem parent?

It is characteristic of these adults that they most often have suffered these crises at the hands of their own parents. The very people they needed to depend upon were the people who were inflicting the crises upon them. They were often violently physically and verbally abused and punished. Their parents often carried out

threats of desertion as well as threats of sending a child away.

As children they viewed the drunken rages of their fathers, with violent scenes of furniture being smashed, doors to rooms being broken down, mothers assaulted. Many saw excessive drinking on the part of their mothers, coupled with open promiscuity. While they were growing up their family environment was often filled with screaming, fighting, accusations, and counter-accusations.

They cannot recall from their child-hood any moments of genuine tenderness and affection. If one of their parents died or deserted, the other parent was incapable of helping them deal with the loss. The remaining parent was usually preoccupied with the meaning of the loss personally and had no energy to recognize that the child was also suffering. The child depicted above is the parent in today's chronic problem family.

These children have grown up emotionally traumatized, often physically abandoned, banished and left largely to their own devices, struggling to survive in the midst of family chaos. It can be seen how they grew up with thought disorders, poor reasoning capacity, bizarre fantasies, self-devaluing thoughts and confusions about who they were or to whom they belonged. They had little energy left to cope with the demands of society around them, such as school. Their childhood experience left them, moreover, ill-equipped to become good parents themselves when they reached their adult years.

It can be seen that in our contacts with parents of chronic problem families we are making demands on people simply because they are of a chronological age which presumes a sense of self-responsibility and control. Recognizing that they never had the where-with-all to achieve such growth is not only of diagnostic significance; it helps to reduce some of the anger toward them.

Character Disorder Parents

One group of parents was most savagely affected by the crisis of loss in their own childhood. This is known as the character disorder group.

Their reaction to the loss becomes the subsequent central theme in their life experience. The original loss may have been the death, desertion, or sustained emotional withdrawal of one or both parents during the early years of their lives. The result of the loss is that a constellation of ideas becomes fixed in their minds. The constellation persists because they have no real way of overcoming or mastering its deleterious effects. This constellation includes: 1) the idea that the parent left because the child was bad, 2) the idea that the parent hated them for their badness and chose this way of punishing them, 3) the idea that they are unworthy of love, otherwise the parent would have stayed, 4) the idea that adults are not to be trusted because they leave, often impulsively, without warning or without sufficient explanation, 5) the idea that any future relationship with an adult is not to be trusted because the desertion will be repeated.

In addition to the process of taking in these distorted ideas, there is the concommitant real impact of the loss, which results in a stunting of the growth process. Thus the increasing gap between the child's chronological age and his arrested emotional development. The demands and expectations of society causes further tension and conflict. One of the first areas of observable breakdown comes when these children first go to school. They show poor performance and behavior disturbances, often not in keeping with their intellectual potential.

The loss leaves these children in a sustained and unresolved state of intense anxiety from which they never are able to escape. In desperate, repeated attempts to resolve this anxiety and put to rest the feelings of tension, they are constantly in motion. They are always seeking for someone or something in the environment to fill the sense of emptiness that the loss has created.

The girl who carries an illegitimate child says during her pregnancy: "I feel filled up again." She is really saying she felt lost and empty inside. An examination of her childhood history will reveal that she lost one parent at a very early age, usually after a period of violence in the home. She was left with a feeling of anxiety at the time of the loss, accompanied by a feeling of emptiness. In her roamings, which are in part a search for the lost parent, she will meet a boy or man who will be tender and gentle with her. He will hold her in his arms and make her feel warm and wanted, and these acts will produce for her temporary cessation of the empty feelings. The fact that she becomes sexually involved is actually incidental and was not her

guiding wish. Most girls who become pregnant for these reasons cannot recall the actual act itself and only remember the sensations of being held and wanted. The child inside the body fills the sense of emptiness and carries over for her the sensations of warmth, being wanted and being cared about. It is very often true that the father of the child means little to the pregnant girl and she may never want to see him again. She will often fantasy during pregnancy that she will care for the child as she wished to be cared for. Since the whole process is unreal to begin with, and only relates to the girl's wish to find her lost parent, the illegitimate child has little real meaning for her. This is confirmed in her subsequent behavior toward the child which may include neglect, abandonment, or turning the child over to her parents for care. If the child is kept, her later expectation is that this child will take care of her.

Often, a delinquent boy who steals will say in his own way that right after a theft he felt whole again. He is also expressing a sense of emptiness and loss of a parent. The stealing for him has a brief restitutional meaning and in his fantasy it fills the emptiness within him, as if the feelings themselves are the return of the lost parent.

There are other feelings, along with those of loss, which are quite significant in understanding the repetitious behavior of the chronic problem parents, especially in their inability to trust. They have been so hurt by the original loss that they are not able from that point on to come close enough to anyone to master the

feelings of anxiety that are mobilized in a close relationship. At the same time a fantasy is kept alive that the original parent will return and in a child-like way everything will be all right again. They are thus people caught in a trap; there is a strong wish to get close, a fear to get close, and a need to keep the entire process going to satisfy the underlying, though unreal hunger for the lost parent. Methods of handling this problem are dealt with in the section on "Treatment".

These are often chronic problem parents who run from agency to agency and from facility to facility, often making unrealistic and impulsive demands, failing to follow through on any sustained basis. They are "acting-out" the never-ending search and problem described above.

Schizophrenic Parents

The schizophrenic parents are a much sicker, more primitive group. There is less a problem of loss here, although loss occurs in the histories of this group. A much more serious problem has to do with self-perception.

There is strong evidence that a psychotic inter-action takes place between one or both parents and child in the early family history of this group. The psychotic inter-action allows for no real separation between the parent and child. There exists what is called a "symbiotic" relationship between them in which the child is viewed as an extension of the parent rather than as having an identity of its own.

This extension is defined by the parent as a bad part of himself and as a result, the child right after birth is handled, thought about, and talked about in this fashion by the parent. Consequently during the first year of life and later, the child may see itself as bad, dirty, crazy, dangerous, violent, odorous, ugly, murderous. In its ultimate, the child is really the outside representation of the parent's feeling about herself or himself.

Every act of the child's is perceived in this distorted way and the inter-action between parent and child literally can turn the child into exactly what the parent perceives. These are children with mammoth rages, who manifest "crazy" or "odd" behavior, who commit the more serious crimes of violence, both as juveniles and later in life.

This is often the "15 year old, quiet, honor scout" who kills the girl next door. Somewhere in the newspaper description there may be evidence that this boy, while growing up, manifested "strange" behavior. His mother will report that there were times when he acted "funny". A further study of his history will usually reveal that his mother thought there was something "funny" about him right from birth.

While most of the chronic problem family parents are not caught up in the extreme of murder, there is a whole continuum of lesser, but nevertheless significant, incidents of violence in this group. These parents when they were children might have been punished by having their hand plunged into a lighted gas burner because they played with matches. They might have had their faces

rubbed into the urine-soaked sheets because they wet their bed. Their lives were characterized by more brutality and violent sadism than others who are now parents in chronic problem families.

The process of disintegration mentioned above starts in the first year of life and is filled with fantasies of terror and catastrophe. When these children grow up, they talk more of "huge, engulfing fires", terrible "floods and earthquakes". They are more concerned with world destruction; they see the world peopled with savage, dangerous enemies. They tend to be more isolated and more vague in their contacts with agencies and facilities. They are more quickly paranoid about why they are being contacted and are apt to be violently hostile and abusive.

Conversely and "perversely", they may be quite active in certain community affairs, particularly in school and church functions. However, upon close examination, it is found that their social contacts are basically cold, superficial and quite unfeeling. Here, too they are quick to withdraw and to claim that people are unfriendly and "out to get" them.

Mixed Group

Many marriages of parents of chronic problem families come about because the parents see in each other the opportunity to fulfill unmet needs. This is in contrast to more reasonable motivations for marriage which presume, for example, a sharing of each others' strengths to achieve mutually constructive and pleasurable fulfillment.

In the mixed group, evidence reveals that character-disorder and schizophrenic parents may marry each other. It is not clear why these groups gravitate toward each other. But it is clear that most chronic problem parents marry out of "feeling" alone, with little reasoning, or at best, faulty reasoning.

Often-times, the lonely, rejected schizoid boy appeals to the searching, impulsive, character disorder girl. She sees her own sense of loneliness in him and wants to give to him and to be given to. At the same time, perversely, his schizoid quality makes it safe for her to marry because he will not allow her to get too close to him. This meets her need to stay away from people to avoid being hurt. Also, later in the marriage, when he neglects her or is isolated from her, this will give her permission to become promiscuous and continue her search for her own lost parent through this promiscuity.

Problems in the Sexual Area: All Groups

A major problem for all three groups of parents concerns their psycho-sexual adjustment which is arrested concomitantly with their general emotional growth. There is much evidence that sexual activity and aggressive behavior are fused in the minds and feelings of these parents.

In the character-disorder parent, sexual activity is impulsive, and does not reveal any mature sense of mutuality and sharing of of an experience. Anger and sadism are much mixed with the need to be hurt and punished and the sexual act is often used to express these needs or gratify them. At the same time family

interaction is marked by violent quarrels and physical abuse, savage jealousies and rages, running away from each other, and prolonged drinking episodes. All these factors obviously set the stage for pathology in the children.

Often-times the birth of the first child will throw the parents into heightened tension with each other. If the first child is a boy, the father usually feels deeply rejected because attention is taken from him; this repeats his earlier sense of loss and he is apt to reject the child. The reverse happens less often, but occurs if the mother is over-sensitive to the father's attentions to a female child.

The parents often attempt to use the child against each other, with the result that the child runs between parents, feeling insecure and frightened by the need to choose sides. The child, in self-protection and the need for survival, may turn this to his own ends and may learn to manipulate the parents for gain. Thus we see the manipulative technique in many of these adults as they carry this phenomenon over from a disturbed childhood.

In the schizophrenic parent, sexual activity may be perceived as dangerous and frightening, something to react against violently. It may provide temporary relief against over-whelming anxiety. This is especially true in the schizophrenic group where the promiscuous mother may say she would have gone "crazy" unless she had permitted the promiscuity. She is not talking about a sexual overdrive related to nymphomania but is expressing how she defended herself against intolerable anxiety.

For both character disorder and schizophrenic groups, sexual activity never achieves a full heterosexual meaning from which a sustained love relationship can develop. All of the problems about closeness are brought into the sexual sphere and it becomes laden with tremendous anxieties and tensions. This results often in latent or active bi-sexuality and often accounts for the so-called "homo-sexuality" practiced. This is actually more a confusion in masculine and feminine identity. With all the other problems, this confusion affects the family structure and accounts in part for the generational transmission of ideas and values as well as emotional tone in these families.

Summary

In general, chronic problem parents grow up out of a childhood of great emotional impoverishment, inconsistency, confusion and disorder, often with deprivation of food, clothing, and shelter. Many of the following characteristics are manifested by all three groups of parents.

They do not see people in a total way, but rather as someone who gives or takes. This often throws them into competition with their own children and at times accounts for the situation in which the children are cast into the role of "parents", giving to the real parents.

Their reality-testing is poor; their judgement is poor; they are rarely able to follow advice or sustained plans for the future. Impulse gratification takes place at an infantile level and is

often not in keeping with reality, thus becoming self- or outer-destructive.

Their thinking is often filled with magical thoughts in which someone will come and rescue them from their fate, or in which they achieve grandiose success without effort.

Another route for handling their inner tensions is by turning them onto their bodies. Many of the physical ailments which they suffer are a way of externalizing their difficulties. Although the physical disabilities are very real, their derivation lies in turning of the attack on the outside world inward onto their own bodies.

These parents project their problems onto others, feeling everything that happens is being done to them by other people. Projection is a method of disowning a feeling which enables a person to avoid taking responsibility for his own acts or feelings. Thus, if one of these parents commits an act against the other, he says: "She made me do it; she's to blame, not I."

These parents will deny problems completely or minimize them in a way that is often mistaken by other people as indifference or carelessness. It is often a way of masking the enormity of the problem from themselves, because the feelings of anger or the drive for acquisition behind the act may be too strong for conscious awareness. Another reason for denial may be in their not knowing why they commit a certain act nor are they able to remember the feelings prior to it. They rationalize a good deal of their behavior in an attempt to explain it away, to minimize its

importance, or to avoid examining what they have done.

There is an absence of observable guilt about most of their behavior. It is questionable, whether when they do verbalize a feeling of guilt, whether it is true guilt, or simply a feeling of remorse which is brief and transitory.

They often behave as if things are coming to them. This is related to their intense underlying anger at having been deprived as children.

Family Structure

Within the general descriptive term "chronic problem families" there are many sub-groups. It is important to make these differentiations in order to improve management and treatment programs.

It is clear that 1) constellations of difficulties vary in quality and quantity from family to family; 2) the strengths and weaknesses of the families as a whole and of individual family members vary from family to family; 3) the person (father, mother, child) who controls the family may be different from family to family.

A crucial finding has to do with the manner in which family roles shift from time to time within a family. In reasonably healthy families, the role of mother, for example, remains fairly consistent. The children come to expect the security which this knowledge brings. By the same token, the father as the wage-earner, maintains a consistent and respected role which provides security to the mother and the children.

In chronic problem families, this consistency is lacking. For example, there are families in which, though all of the family members are present, the primary wage earner is the oldest boy. Or the role of mother may be taken by the oldest girl. Even this structure may shift quite often, contributing to insecurity and confusion.

Inconsistency in Role Definition

We can see several categories of family structure by utilizing this inconsistency in role definition.

In some families, with the father present, the mother is the supplier of food and care and is the wage earner or provider of funds through her contacts with social agencies or welfare. The father in this family will have severe, chronic medical and/or psychiatric problems. This in itself would not be so devastating if it were not for the fact that the mother often bitterly resents her dual role. She is so devaluing of the father that the boys in the family identify either with this strong part of mother or with the sick father in a way that destroys their opportunity to become adequate males.

A shift may suddenly occur in this family when the father, angered and humiliated by the mother's attacks, suddenly attempts totake over the role of provider. The resulting confusion only throws the family into further turmoil.

There are many families where the father is enough of a wage-earner to assume a superficial consistency in this role.

Unfortunately, he neither sustains it regularly nor gives it up completely, and the result again is tension and persistent insecurity for all.

In many families, the children are cast into the parental roles upon reaching early adolescence. Obviously they are not suited for these roles. Thus, an adolescent girl may be trying to go to school and care for a number of younger siblings at the same time. Here again, the mother may, from time to time, try to take this role back. Further chaos results.

Some Explanations

Viewed psychodynamically, the role shifting is related to several factors in the individual dynamics of the parents. To begin with, their infantile sexual development and their inability as they grew up to make proper identifications with the parent of their own sex leads to marked insecurity and inconsistency in assuming the proper role. There is basic confusion in masculine and feminine identification on the part of both parents. They are both victims of families where the comings and goings of parents and the violence of behavior made it impossible for them to achieve and consolidate the proper identifications.

In an effort to master this complex problem, as children they shifted back and forth, first identifying with one parent and then with the other, partly in a desperate effort to find some security. When a parent died or left the family, the identification process suffered a telling blow and was almost impossible of resolution.

In those instances where the parent-child interaction was psychotic, no real identification could be achieved at all.

This confusion of roles continues into adulthood and into marriage. Underlying the confusion in masculine and feminine identification is the general insecurity which has to do with fear that their basic needs are not going to be met.

Essentially, these parents do not trust each other, even though they married to fulfill their unmet needs. Thus, the slightest threat to security is met with panic. If the father stops earning, the mother, instead of supporting him through this period, turns on him and either gets a job herself or runs to a social agency for help. At the slightest hint by the mother that she is tired of the role of housewife, the father panics and may turn on her, may quit his job and take over the household chores, letting her go to work. As soon as the oldest girl reaches adolescence, and sometimes even earlier, the mother may look to the child as the surrogate mother and may turn over all her responsibilities to the child. The oldest boy may be pushed into replacing the father; the mother may throw him into open competition with his father.

The simplest crisis may throw roles into confusion and a violently pathological interaction builds up. The daughter, who has been cast in the role of mother, may flee into delinquency to escape. The son, cast in the role of his mother's favorite even over the father, may flee into delinquency to escape the over-seductive situation.

The daughter may decide she likes the mother role and if the mother attempts to take it back, a terrible struggle insues. The father may decide to stay at home and take over the mother's role; the

mother goes out to work, soon tires of this effort, but finds that the father is reluctant to give up his passive role.

These identification-sexual confusions, coupled with general insecurity about having needs met, are rife in the every-day living patterns of these families. This accounts in large measure for breakdowns and shifts in roles with the attendant spill-over of problems into the community.

Community And Environmental Problems

Manipulation and "Running"

The environmental and social adjustment of chronic problem families reflects their conflicting, disturbed behavior patterns. They use the environment manipulatively, making incessant and unrealistic demands upon it. This manipulation often takes the form of playing off one social agency against another, the church against the social agency, the school against the clinic, the community center against the probation department.

They do this by running from one service facility to another, distorting the nature of their contact with each other, often telling a probation officer one story and the minister or priest another. They never tell the whole story in one place, but reveal only parts of it. This makes consistent helping extremely difficult. By this technique, they continuously reestablish a crisis situation in which agencies end up competing with each other, often falling into the trap which the family has set.

Such manipulative techniques often alternate with an appearance of helplessness. In this helpless state, the family

feels it is completely the victim of outside forces and operates in an extremely dependent fashion which throws the burden of responsibility completely onto the helping services. In this state of passivity they will often follow the advice of agencies so that they appear compliant and eager to receive help. Unfortunately, such dependency has a strong, hidden, hostile component and compliance will often turn to resistance and ultimately to sabotaging the plan.

Taking these two major methods of relating to the environment, we can consider some of the problems which arise. These are parents who will often either avoid or fight with school authorities over issues regarding attendance and behavior of their children in the school setting. Such activity will provoke the authorities into hitting back. The parents will then run to another agency and complain bitterly about the treatment they and the children are receiving at the hands of the school authorities. Unfortunately the facts are often true as reported by the parents. What has not been reported is the process by which the parents have gotten the school authorities angry enough to exert pressure or punitive action. They produce the same reaction from landlords and fund-giving agencies.

The Problem in the Neighborhood

In relation to their neighbors, parents in chronic problem families often feel picked upon, looked down upon; they are extremely sensitive to criticism about themselves and their

children. They cannot maintain sustained contacts with neighbors. They can rarely participate in neighborhood planning. They are unable to maintain any sustained contact with community and recreational facilities. The adolescent children of these families often act destructively against a Community Center of recreational facility which ultimately brings about their exclusion. This further reinforces their feelings of not being wanted and sets in motion the cycle by which this becomes the provocation for further destructive behavior.

They are usually outside the spiritual strength of the church and use the church as a source of supplies in time of crisis. The religious education of the children is extremely spotty and very little in the way of a religious philosophy has been incorporated into their way of life.

Educationally, they have rarely achieved a high school education and college is rarely thought about. The children in these families are often in special classes or are achieving poorly in the regular school program.

Cultural Considerations

There is no question of the importance of considering culture patterns as an integral part of understanding and treating chronic problem families. They include people with varied religious and ethnic backgrounds who come from many different geographical areas. Some come from cultural backgrounds with matriarchally-dominated families, while others come from backgrounds with patterns of

patriarchal dominance. Their ways of looking at things, their value systems, customs, methods of communication, attitudes towards religion, education, work, their child-rearing practices and sexual practices - these are all important in understanding each family and each person within the family. Work with Puerto Rican families, Negro families, white families is much less effective if one does not understand these cultural differences.

There will be no attempt here to delineate all the cultural patterns among chronic problem families. This report will deal with cultural considerations in three ways: 1) to discuss a few issues which need to be clarified in order to define the position of cultural factors in the total understanding of chronic problem families; 2) to delineate a fourth group of chronic problem families who evidence more "culture conflict" than psychopathology; and 3) to suggest methods by which cultural factors and psychodynamics may be woven together to broaden our understanding of these families.

1. Some of the Issues

What has already been said in the preceding paragraphs is in frank opposition to the notion that these families are members of a sub-culture which accepts its way of life and is generally happy about it.

It is quite possible that cultural patterns transmitted from generation to generation may have within them a pervasive quality of defeatism, negativism and self-devaluation. This may influence the level to which a group might feel it can aspire. But to allow

this concept to be used as a way of describing the feelings of chronic problem families as "accepting and happy" about their lot is to give cultural factors a weight which they do not have.

This distortion of the role of cultural factors in understanding chronic problem families leads, for example, to the notion that attempts to help these families are an imposition of middle class standards upon people with lower class standards. It denies that all people may have similar feelings about most things and further it is implicitly contemptuous of the so-called lower classes' potential of achieving change for the better. It also arbitrarily disregards whole groups of low-income families who live in dignity and self-respect, often making it possible for their children to take advantage of "middle class" opportunities and ultimately to move into the "middle class" when they grow up.

This distortion of cultural considerations further accepts the notion that chronic problem families have a "right" to self-destructive, defeating behavior. It fails to differentiate between 1) the rights of minority, ethnic and religious groups to cherish their customs and values, and 2) the disorganized efforts of unhappy, frustrated and misunderstood people to maintain themselves in an environment in which they are ill-equipped to compete or which they do not comprehend because it is so different from the place they came from.

A true understanding of the meaning of culture requires 1) studying peoples and communities in a historical perspective which traces the transmission of values down through the generations,

and 2) studying changes in a community, how the community has reacted to particular families and what effects this has had on these families. The impact of political and economic changes on a community, shifts in its ethnic or religious composition, urbanizations, migrations - all these have an impact on families. The influence of historical developments on family life and on the transmission of cultural values has been too often ignored. The disregard of these factors may be due to an unwillingness to throw the past open to scrutiny, to recognize the real attitudes of one group toward another, and to see how these attitudes may have perpetuated the condition of chronic problem families.

In summary, it is recommended that 1) cultural patterns be given serious consideration for the purpose of understanding and working with these families; 2) that the potential cultural strengths in these families be utilized in the process of working with them; 3) that cultural patterns that tend to defeat self-expression and achievement of potential be viewed not as an inalienable right, but in part as distorted values and ideals which have been effective in keeping such families trapped in the multi-problem vortex.

It is proposed that such an approach to the meaning of culture and its influences will help reduce the negative stereotypes with which these families are labeled and will reduce the tendency to use class differences to discriminate against a particular group of people.

2. A Fourth Category of Chronic Problem Family

A fourth group of chronic problem parents includes those who have migrated from other parts of the United States or from other countries. These parents are much less the victims of disturbed early childhood and are more the products of a society which has different cultural standards than those of the neighborhood into which they have moved.

If they come from a culture where education is less valued, they will have extreme difficulty in understanding the premium which is generally placed upon this and may come into early conflict with the school system. They may have different values regarding property rights and may thus view the destruction of property with less concern. Unless the cultural conflict is perceived early, the problems arising from it will soon result in a deterioration within the family and the picture of chronic problems will emerge.

Psychodynamically, the history of these parents will not show the characteristics of the parents in the first three categories discussed under "psychodynamics". However, we can see the making of future chronic problem families before our eyes if "culture conflict" developes and is allowed to flourish or is perpetuated by misunderstanding. The parents are soon caught up in a struggle with the environment.

In the subsequent heightening of tension, their emotional strength may be so sapped in dealing with the conflict, that parent-child relationships may deteriorate. The children in these

families may begin to manifest the symptoms leading to some of the pathological developments described earlier in this report.

3. Methods of Viewing Psychodynamics and Culture

We will suggest here an approach to weaving culture and psychodynamic factors into a meaningful contribution to the understanding of chronic problem families.

In any group, cultural patterns include certain ideas about feelings and certain attitudes toward one's self and toward others. The culture also provides a guide to behavior in reference to these ideas. For example, if it is not considered appropriate to show emotion when grief is experienced, then this idea about feelings prescribes the appropriate behavior. There does not need to be a known rationale for such an idea; it may simply be an idea that has been transmitted through a particular group for a thousand years. This way of handling grief is considered normal by that group. If someone in that culture cried instead of being impassive at a time of grief that person would be considered abnormal.

A family coming from a particular cultural background may come into conflict simply by moving into a community which differs in specific culture patterns which are important both to the family and the community. The mother in a family moving into a neighborhood may not feel it is necessary for her child to go to school. Where she came from nobody worried about school particularly. In the mother's mind keeping the child out of school may be culturally appropriate, but in the eyes of the community her attitude and

behavior are anti-social and may even be considered pathological. Unless the problem is resolved peacefully and with understanding, tension is heightened. This may drive the family deeper and deeper into trouble, with a resultant breakdown in family functioning and the concommitant effects.

A much more complicated situation arises when a family is culturally different from the community around it and in addition has pathological problems which put it into conflict with its own cultural group. For example, in Puerto Rican culture, the father normally conducts all outside contacts with the community. The mother's task is to stay home. If such a family moves into a neighborhood and the father should refuse to carry out these functions and the mother does so in order that the family can survive, we see a culture conflict both within the family and without. The conflict from without comes repeatedly as such families run into the different value systems in the community around them. The family is struggling with conflicts on two fronts and, because of the intensive internal conflict, it has little energy to deal with the equally strong external conflict. This may sometimes explain in part the bedevilment that besets chronic problem families and the overwhelming sense of helplessness which pervades the atmosphere around them.

Another fruitful possibility for studying the interweaving psychodynamic and cultural factors may come from exploring different explanations for the same kind of behavior. Our example

has to do with rage and the handling of such feelings. Two ways of expressing anger are described below. The first has to do with an unconscious process as described in the psychotic interaction between a schizophrenic mother and her child. The second has to do with culturally approved ideas. Both processes can lead to the same kind of behavior.

In the discussion of the schizophrenic parent it was pointed out that the child developed a distorted self-image as a result of the parent's feelings and ways of handling the child. This distortion could lead to rages and in some instances to acting-out murderous impulses. Such psychotic interaction is unacceptable in our culture and is treated as pathological.

The Mic-mac Indians are taught that feelings of love and friendship toward family and friends are to be on the surface, but feelings of hatred are really the most important and must be kept secret. Thus, Mic-macs pretend to love each other and relish hatred for each other in secret. It is culturally approved for these feelings of hatred to come out when Mic-macs become drunk. This often explodes in rage which leads to murder.

Two ways of handling feelings can thus result in the same end - murder. In the case of the schizophrenic parent-child interaction, the process is seen as culturally-disapproved and unconscious. In the Mic-macs, the entire process, except for the end result, is culturally approved.

It is felt that methods of analysis that bring to bear our knowledge of psychodynamics, of family structure, of community

conditions and of cultural factors will add new and useful dimensions to our understanding of chronic problem families.

Treatment

Introduction

Treatment approaches to the chronic problem family need to be discussed from several points of view. A salient point concerns the externalization of problems which is one of the major characteristics of these families. This externalization causes the families to be in continuous and chaotic conflict with the community.

Many agencies and service facilities may be working with one family simultaneously. This may come about either because the family has requested help or because one or more of its members are in trouble, or both. A prerequisite to treatment requires that agencies coordinate their efforts in a generally agreed upon plan. Otherwise they will be perpetuating the confusion which pervades the life experiences of these families. Inconsistency in planning, which can only lead to confusion, stands out in the following example. Three agencies were working with a chronic problem family. Each had a specific, clearly defined function. One of the children was in placement. The placement agency was clear on its role and was providing the child with an excellent remedial experience.

The second agency carried an authoritative function in relation to the child in placement. The agency had the right to say whether the child should continue in placement or not. The third agency was working with the whole family and had been helpful

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in arranging the placement after the child had gotten into trouble.

These agencies rarely communicated with each other. Everyone was "too busy". After the child had been in a placement for a year, the placement agency had this to report: "This child has done excellently, has shown remarkable recovery strength and is ready and wants to go home. The parents want her home. We recommend her return." The worker from the second agency said of the home situation: "It is chaotic, bad - no better than when the child left. The parents do not really want her home." The third agency stated: "This child has done excellently in the placement because the placement setting has provided her with the things she needed and could not get at home. There is no evidence that she has as yet internalized sufficient of the gains to maintain them upon a return home and it is an error to assume that her behavior in placement will carry through if she goes home."

It was not until a meeting of the three agency representatives was held and the issues clarified that it was decided the child should stay in placement.

In the meantime, all three conflicting ideas were being transmitted by workers to both child and parents. The girl was told by the placement agency that she could go home, by the authoritative agency that she could not, by the third agency, "maybe". Such confusion could have been avoided (as it finally was) only by the closer working together of personnel involved in the case.

In a previous section it was mentioned that chronic problem family members manipulate or play off agency personnel against one another. It has often happened that a probation officer and a social worker become quite angry with each other because the child they are both working with tells inflammatory stories back and forth. This problem is reduced if agency personnel are working together.

1. The Working Relationship

Another issue concerns the often used term, "working relationship". Clinically, this defines a level of interaction between worker and client (or therapist and patient) which, when achieved, permits a treatment process to take place. Any change for the better in pathological behavior requires a relationship to exist between the sick or troubled person and the helping person.

In dealing with the chronic problem family, it is clear that a "working relationship" is essential to the development of an effective rehabilitation program.

It is germane at this point to discuss the terms "treatment" and "rehabilitation". Treatment here is not considered in a restricted clinical sense. It refers to any and all forms of planned interaction which may take place between social agency workers (or other professional persons) and families. Obtaining new housing, giving food in an emergency, tutoring, counseling, psychiatric and casework treatment, placing a child on probation - all such activities designed to foster change for the better are considered part of the treatment.

One of the serious problems which interferes with agency cooperation is the failure to recognize that all such activities must be viewed as treatment. The exclusion from cooperation of any services that are provided to a chronic problem family has two undesirable effects. It shuts out a source of information with the family. It reduces the possibility of greater change through effective coordination and maximum use of services.

For example, the act of controlling a delinquent child by placing him on probation may be as vital to his ultimate rehabilitation as psychotherapy. It has beenfound that with the delinquent children a combination of probation and psychotherapy is far more effective, where both are indicated, than when one method is used without the other. This is because the therapist is not in a position to provide the external controls often required by these children. These controls are offered through probation. In addition the probation officer by establishing a relationship with the child can help him through those periods when treatment becomes too intense and the child wants to flee. Such division of emotional avenues is often helpful to members of chronic problem families.who find it terribly difficult to invest wholly in one treatment person.

The amount and kind of "rehabilitation" that can take place depends on many factors. But there is no reason to feel that the goal of sound mental health for these families is unattainable. This is a justified scientific and humanistic goal and failure to accomplish it in any given situation should not deter further efforts to achieve it. It only requires continued efforts to deal with the problems and the determination to overcome obstacles, even though at the present time knowledge about these families is still limited.

A second important limitation is our present inability to cope completely and successfully with the extent of pathology that

exists in many family members. In some instances, the psychotic process in a parent may have reached the stage where prolonged psychiatric hospitalization is necessary. This may cause disruption of the family as a unit and placement of the children. Personnel must be prepared to take this step if it means that the children will be less damaged by having the parent hospitalized.

A third limitation lies in the difficulty of obtaining the special services often required by these families; they may be too expensive or unavailable. For example, where it is known what is needed (e.g. special education for children in the form of remedial tutoring), this is often not available or too expensive. Another major limitation is the lack of trained staff which accounts for continued gaps in service.

In thinking about rehabilitation for these families, it is crucial to assess as quickly as possible the goals that are attainable and the limitations that will impede treatment and rehabilitation. Setting up realistic goals always carries the proviso that new goals can be established after a time if they seem attainable with a re-assessment. This is done through comprehensive evaluation which must begin at the point of first contact with the family and is subject to continuous review.

Understanding what goes into the working relationship begins with understanding the various ways in which requests for help are made. There is increasing evidence that chronic problem family members do not know how to ask for help in the usual ways. Underneath the most superficial request to a social agency,

underneath a child's unmanageable behavior in school, underneath the commission of the most serious kind of crime, there may lie an intense plea for help.

The manner in which such requests are handled from the outset will determine the future effectiveness of the working relationship and treatment. It has been pointed out in many studies that at the first contact these families are usually angry and resistive.

> In one family, the children would signal the mother when the worker came into sight and the mother would hide. This happened because on the initial contact with this family, the worker showed up unannounced at the home at 7 a.m. one morning to begin an "investigation" of the family. From that point on, the worker could not involve the mother in a working relationship. A second worker going in at a later point did not repeat the mistake and gave the mother ample notice of her impending arrival. A good contact was established and continued.

There needs to be recognition, in thinking about the working relationship, of how quickly and easily workers slip into treating these families as second-class citizens. The behavior of these families and their manner of living often evoke contempt from workers, with the result that their rights to privacy and to common courtesies are not observed in many instances. They are often talked to in a language and manner that degrades them and

takes advantage of their inability to "fight back". They often "strike back" in devious ways which at times accounts for self-destructive and outer-destructive behavior.

If a family does not want to show the worker someone at home who is drunk, it is a mark of respect not to insist on seeing this person, unless there is some specific legal reason for doing so. Following the rules of common courtesy in dealing with chronic problem families often accelerates the development of the relationship.

> A father in one family that needed to be visited was in the merchant marine and rarely in town. Several attempts to involve him in the rehabilitation effort had failed. He refused to answer letters and his wife had no influence over him. Finally, on one occasion, when the worker arrived at the home, the wife explained that her husband was at home but was asleep. It was then close to noon. When the wife asked the worker if she should awaken him, the worker suggested she not disturb him since he had arrived in port during the early morning hours. Five minutes after this conversation, the husband came into the kitchen and met the worker. His reason for getting up was that he had overheard the worker tell his

wife to let him sleep and he felt that the worker must be a decent, understanding person.

The early steps in establishing a working relationship are only a part of the total process. A profoundly important aspect of establishing such a relationship is keeping in mind continuously the fact that many of the parents and children will make repeated attempts to defeat the relationship almost as soon as it begins. In looking at the character-disorder parent and child, it is seen that: 1) they do tend to reach out more easily at the beginning, 2) they yearn to establish a relationship even though they feel it will end in failure, 3) soon after the relationship begins, the factors which tend to defeat it will begin operating again, namely, overt hostility, rejection of worker, rejection of plans to help, evasions, lying, out-right flight.

The schizophrenic parents and children will: 1) tend to avoid the relationship from the outset, 2) give only superficial attention to it under pressure, 3) slip into vagueness and disorientation, 4) become quite tense and ready to flee at the slightest sign of closeness. This is because this kind of relationship is alien to the psychotic inter-action these parents and children are used to and is therefore threatening and dangerous.

The working relationship has many components. Among these are the tasks of: 1) making it as easy as possible for families to communicate with helping services by understanding the many and devious requests for help, 2) providing a reasonable reality

which is firm but non-judgemental and which permits families and individuals some latitude in testing out their disturbed ideas against this reality, 3) offering firm controls which these families often need from the external world in order to offset their lack of internal controls, 4) offering a framework of disciplined and organized thinking through which planning can take place, 5) offering opportunities to family members for continuous self-expression and active participation in planning when possible, 6) offering concrete assistance when advisable and available, 7) making it possible for families to utilize selectively the services which may be needed, 8) acting aggressively in behalf of the parents and/or children when such action is required in emergencies, 9) developing a focused and unified treatment program which leads in the direction of having family members look at their own behavior and helping them bring their behavior under control, 10) continuously assessing gains together with the families and changing techniques from "doing for" to "letting them do for themselves" as this is indicated.

2. Techniques

These treatment tasks mentioned above are some of the pathways through which change can be achieved. Not all of these tasks are necessarily carried on simultaneously. They are timed and utilized as the needs are perceived. Some of the techniques which are valuable in building a working relationship include: 1) reaching-out, 2) utilizing communication, 3) patterning.

The "reaching-out" technique has been much discussed as project after project has recognized the need to be more active with these families. This again has much to do with the ways in which these people reach out for help or, as occurs in many instances, the ways in which they cannot go for help when they need it most.

Generally, a good number of these family members cannot be treated through the routine office visit. The type of interviewing that goes on in an office may be alien to them or so threatening that they can not tolerate it. Many parents are literally frightened of the trip downtown to the agency office. Other parents may not have the carfare for regular trips. Families who have lived in one neighborhood for many years may fear "getting lost" or "attacked" if they stray too far from home. These families are penalized if these factors are not recognized and help provided through the home visit.

Office visits as such should be encouraged when indicated and can be used as a way of measuring a parent's or child's increasing strength to come away from their neighborhood and also their investment in the treatment relationship.

Home and school visiting and taking parents and children for hospital visits are all part of an armament of treatment techniques that are useful. Home visiting requires an acceptance of the ways in which these families often express their problems. A depressed mother, feeling deprived, will often manifest her feelings through the way in which she keeps house. A dirty home is often

a clue to the parent's and the family's emotional state, signifying depression and apathy.

To make home visits unannounced, in an "investigatory" way, will only abort a valuable part of the treatment process and create anxiety and resistance in family members. Many mothers, when they know in advance that a worker is coming will clean up an otherwise messy home. This is an indication of capacity to mobilize and is an important tool in understanding strengths in the mother. If the house is dirty and disordered for an announced visit, it is usually because the mother wants the worker to see her in this emotionally upset state.

Workers need to be prepared for sometimes "shocking" housekeeping conditions. They must be prepared for countless interruptions during their visits, especially at the beginning of contacts. Mothers will often keep their children in the room with them because they are afraid to be alone with the worker. They will keep the television on loud because they do not want to talk or are afraid of the worker. It is quite a simple matter to ask them to turn the television down. On the other hand, it is often advisable to allow them to have the children with them at the outset.

The same phenomenon occurs with office visits when parents and children are unwilling to remove overcoats or jackets until after they have been making visits for a period of time. They will often keep their coats and jackets fully buttoned. This is another way of protecting themselves against getting too close and involved.

Another factor which must be taken into account is that of communication. Many chronic problem family members are essentially "non-verbal". It must be kept in mind that they most often use physical activity to express themselves and their anxieties rather than extensive conversation and reasoning. Thus "motion" is a key way of coping with their anxiety. Sitting still and talking will often frighten them at first and will only come about after they are comfortable and deeply involved with Workers. Even then, there are periods of withdrawal and reticence.

This matter of communication varies from person to person and must be recognized early. Workers must be prepared to talk openly at greater length and must not allow interviews to become silent. Silence frightens many of these family members and they will need to flee from the worker. They usually see silence as hostile and dangerous and cannot tolerate it. Often taking a parent or child for a walk will be far more effective in opening up communication than attempts to get them to talk about themselves in an office or in the home.

It is also important that workers answer questions about themselves honestly and that they do not hedge with family members. Such hedging is quickly perceived and felt as a rejection by the worker.

The third technique - "patterning" - is an excellent method of working with chronic problem families. Most chronic problem families are not ready to look at their behavior in a reasoning way until after the working relationship has been in effect for a long

time. Workers are often fooled by a superficial appearance of self-awareness when it appears early in the relationship. It is a "false" awareness and should not be taken too seriously. If it is taken seriously, the worker begins to expect things from the parent or child which they are not capable of producing and the resultant tension can often impair the relationship.

Attempts to get chronic problem family members to develop deep insight is unavailing and dangerous. No matter how well the dynamics of behavior are known, the unconscious processes should never be discussed with them. They will become terrified and flee, and in rare instances, this type of discussion can produce psychosis.

However, a very successful method of developing an effective treatment program is through the use of patterning. Patterning is calling the client's attention to certain of his behavior patterns. For example, a mother comes to an agency because she lost her welfare check. She needs funds. The agency should provide the funds but should also point out to her how she has hurt herself by losing the check. Other incidents of losing things should be elicited from her. When it happens again, as it usually does, the funds need to be provided again and the patterning must continue.

This patterning will go on around many of the person's problems. It is a persistent, yet gentle way of continuously forcing these people to look at their behavior without depriving them or punishing them for their actions. It is non-judgmental and is not

advice-giving, although advice-giving may be required in some situations. It is really a process of continuously saying: "Let's look at this together and see what happened and try to figure out why."

The patterning must be continued even during the most serious kinds of crisis. Sooner or later, family members begin to utilize this technique on themselves. Only when it reaches this stage does it become meaningful to them. This is different from lecturing and exhorting; it requires patience and persistence because the answers it seeks are not immediately forthcoming. For a long time, family members will resist looking at the "why" and they should not be forced to do so.

In discussing relationship and treatment ingeneral it is important to point out that the one-to-one treatment technique is only one method of helping these families. Family conferences are an important and useful method of moving treatment along. Group education programs and group therapy have been found extremely meaningful, especially to mothers in chronic problem families.

Volunteers who can carry out dozens of concrete tasks with these families, under supervision of trained personnel, are a valuable and willing group. Case aids can also fulfill many of these functions under supervision.

3. Crucial Issues

Four other issues need to be discussed under treatment, and while they involve relationship and technique, they are somewhat broader in scope.

In the section on culture, a type of chronic problem family was described as having less pathology and more culture conflict. This possibility highlights the need for extensive and skilled evaluation and diagnosis. It calls for careful consideration of all possible factors as guides to planning treatment.

There is always the danger in avoiding certain stereotype of creating a different kind of stereotyping in its place. Always to look for early pathology where it may not exist (or exist only mildly) is to run the risk of over-treating a family and not meeting its real needs. However, it is crucial to recognize the depth and extent of pathology in order to determine how much treatment is required. This can be evaluated by careful assessment of current behavior, response to suggestion, and capacity for follow-up.

One chronic problem family had as its core problem the fact that the father could only earn $50 a week. This was the extent of his capacity. There were seven children in the family. The strain of trying to manage was having a corrosive effect on the mother and father, and was showing in the children in delinquency coupled with enuresis. A thorough assessment of this family showed exceptional strengths in both parents: a genuine, loving interaction between the parents and the children, and a strong drive to fit in with the cultural demands of the community. When the father's earning capacity was increased, an immediate transformation took place. The delinquency and enuresis stopped and the family was back in equilibrium.

Such a case is a warning that many families in chronic trouble may be suffering primarily from economic pressures beyond their control. They may break down if unattended and show all of the pathology that may be much more of a fixed problem in other kinds of families.

A second salient issue which needs special consideration is the fact that many of these family members feel they are "crazy". This fear is evidenced over and over again and needs to be understood by all personnel who come into contact with them. The feeling is often generated by their own rages and violent behavior. Here again patterning is important because it makes their behavior more apparent and understandable to them and therefore less frightening.

Team work is essential in working with these families. A notion which comes from work with neurotic patients has been applied erroneously to chronic problem families. The notion is that these people should be treated by only one professional person and that they should not discuss anything with anyone else. While this is a sound guide in working with neurotic patients, it is not valid in working with most chronic problem families. The fear of closeness which is so much a part of their basic problems, makes it feasible and even desirable for several people to be involved with them simultaneously.

It is true that chronic problem families will often complain that they have many workers and are confused about who does what. This is not because one worker is desirable. It is because the workers are often working at cross-purposes and are not moving

toward any agreed-upon goal. If workers can be goal-directed and not allow themselves to become confused, the presence of several of them is an asset. There are several people to cover emergencies. If the relationship with one person becomes too intense, the family members can reduce it by turning to another member of the team without difficulty. In this way, strengths are built and relationships are solidified.

Probably the best learning experience for chronic problem family members is to find that five or six workers who are involved in their lives are all unified and thinking the same way about what needs to be done. This provides a consistency that has never before existed for them. This distribution of responsibility among several workers does not rule out the concept of an "anchor" worker or agency; this will be discussed in the final section of this report.

A phenomenon which requires special discussion has to do with the issue of contact disruption. This consists of attempts by families to get the workers to break off contact or to break contact themselves. This will happen by itself, when workers go on vacation, or when one worker leaves an agency and the case needs to be transferred. It will often be at this point that families will regress to previous patterns of behavior in situations where improvement has been noted. They will "run" from workers, fail to keep appointments, or openly tell workers to stay away. At this point, it is imperative not to accept their attempts to break off treatment. Often, it is necessary to make

continuous home visits, write letters and make phone calls in the face of avoidance and resistance. It is extremely trying on workers to go through this period. They are getting the full force of the family's feelings of being rejected and the need to reject in return. This can happen after a week's vacation. However, if the worker persists, the obstacles can be overcome.

Another method of dealing with this problem is frankly predicting it to the family before it happens and then openly discussing their feelings with them during the difficult period. This often reduces the intensity of the problem and paves the way for increased interaction and a productive resumption of treatment.

Implications For Urban Renewal

1. The Problems Implicit in "Renewal"

Seeing urban renewal as one aspect of achieving the American dream provides a useful frame of reference for dealing with the chronic problem family in the context of renewal. The chronic problem family among others, has an opportunity through urban renewal to make a change for the better in important areas of living - housing, schooling, education, religion, transportation, recreation, shopping, etc. It has been pointed out that while the chronic problem family may want to share in this dream, often it does not know how to. From a practical point of view, it is crucial then, to predict some of the problems which will arise in connection with urban renewal and to consider methods of dealing with them.

There will be major problems that need to be faced with these families in areas scheduled for physical rehabilitation. But if dealt with properly, this can become a beginning point for rehabilitation of these families.

It is predicted that more chronic problem families will be "uncovered" in rehabilitation areas, than will be at first discernible in those areas where large numbers of families are to be relocated. This is so because upgrading of property will clearly pinpoint individual families and "nests" of families who can be "lost" or remain hidden in the process of relocation.

This, unfortunately but realistically, may be an opportunity for landlords and neighbors to "get rid" of undesirable and troublesome tenants. The problems must be recognized and taken into consideration as part of the total "renewal" plan. These families are quickly identified by landlords and neighbors and by a cursory investigation of the property which will show marked deterioration as one evidence of the family's problems.

2. Methods Of Dealing With The Problem

There is a great danger, in light of the attitudes of landlords and neighbors and the families' own anxiety about the pressures of "renewal", that many of these families will become "drifters" during the process of urban renewal. They may go from one blighted area to another, in a sense "driven" by urban renewal programs. In areas marked for renewal, this may be true of low income and quite disrupted white families who were not able to move during the recent periods of exodus into the suburbs and

better residential districts. And it may be true of racial and religious groups who may be doing somewhat better financially but are "ghetto-ized" and afraid or unable to move into newer areas.

In reference to chronic-problem families, it is imperative that the urban renewal authorities and social welfare agencies set up machinery for assessing the potential strength of families who are of concern in relation to "renewal" of a given area.

One question which must be answered immediately is how capable is the family of responding to the benefits of renewal with a minimum of assistance? Not all chronic problem families express their problems through failure to pay rent or destruction of property. Even where such things are a problem, often allowances of funds to pay rent and the use of housekeeping assistance are sufficient to help the family cooperate minimally in the renewal plan. This may often mean that the family can stay. This does not mean that they will not need other kinds of help.

Planning should include continued contact with these families. It may make the crucial difference between a family's staying in a neighborhood and beginning to take advantage of the renewal benefits or "fleeing" in the face of changes which they cannot keep up with. Such planning may be the turning point for many families and may mean the differemce between beginning a process of rehabilitation or continuing to receive diffuse, fragmented assistance which accomplishes little.

3. Planning For Relocation

If an assessment of strengths and potentials indicates that extensive rehabilitation of the family will be needed before they can respond to the challenge of renewal, it will be better for the family to be moved into an area that will not make these demands upon them.

It is also possible, with proper diagnosis, to determine whether this is a family with sufficient strength to move into a public housing project. This may be possible or necessary because: 1) the family may need more rooms, 2) they may not be able to meet an anticipated rent increase but could pay public housing rentals, 3) they have been receiving agency help and are ready for the move.

In any event, what is needed is the kind of planning for relocation of these families which will: 1) anticipate the problems, 2) accept responsibility for dealing with these families, 3) set up machinery for dealing with them, 4) follow through on programs with a long-term committment to work toward the family's rehabilitation.

Anticipating the problem will require preparing chronic problem families for the move. There are several ways of handling this. In the case of families already known to agencies, relocation personnel can sit down with social agency representatives and decide to whom the task of preparing families should be delegated. The advantage of dealing with a family already known to one or more

agancies is that much needed information about family patterns and reactions is readily available.

In the event that a family is detected that is not in contact with any agency, it is strongly recommended that a trained, skilled psychiatric caseworker or a person trained in relocation techniques with an understanding of chronic problem families make the contact to prepare the family for the move. They should have training in dealing with hostility and resistance and should have the capacity to form the relationships required to assess the family's reality problems, modes of operation, and to determine what is needed to carry the families through relocation.

If the person who makes the initial contact is not going to continue with the family on a long term basis, some other person who will take up this committment should be brought in before the contact person steps out. Unless this is accomplished, the family will collapse at the point at which the contact person withdraws. Contact persons must know community resources and methods of utilizing them properly.

Funds should be available for the purchase of special services which are needed, either prior to the move or after the move takes place, e.g., housekeeping services, clothing needs, etc.

4. Problems Implicit in Relocation Into Public Housing

It has been pointed out that these families are accustomed to moving often. This section deals with relocation of families into public housing developments. This can become a special

problem because they may remain undetected until after they are in the development, or the problems may not appear until after they have moved.

Whether these families manifest less reaction to moving than most, it is repeatedly shown that they do not react in a positive way to new housing. They tend either to "run back" to older, more familiar areas, or if this is not possible, to recreate the old, familiar settings and patterns. The apartments in new developments become "run down"; the rent does not get paid, and the families are soon back into a familiar hostile interaction with the housing authority, with all that this implies.

It is noted, though the data are not yet systematically collected, that there is a good deal of coincidence in time between change of location for these families and the acting-out behavior of the children. They may keep the apartment looking good, the rent may get paid, but one or more of the children may suddenly start truanting, or commit delinquent acts, often acts of vandalism against the new community, e.g., school, apartment dwelling, church, etc.

5. Recommendations for Public Housing Personnel

However much preparation goes into relocating these families, it is certain that in many instances old patterns of behavior will continue to crop up. It is mandatory that housing managers have available on their staffs trained personnel to take over these families immediately. This type of service is no different than having maintenance men on the staff. Trouble-shooters need

to be trained and equipped to meet the problems and begin dealing with them.

Ample material in this report demonstrates that dealing with chronic problem families is not a simple "common sense" matter. Many of these family members are riddled with severe emotional illnesses. To turn such problems over to personnel inadequately trained to understand or cope with these problems, is to doom to failure any effective rehabilitation efforts.

It is no longer permissible to assume that psychiatry or case work are luxury items or are not really helpful. Such attitudes are hardly short of criminal in the face of the distress of many families in need of special services which can be provided by these disciplines. Such personnel need to be attached to the housing development staff and must be given sufficient responsibility and authority to practice their professional skills in conjunction with other skills available to housing managers and to the families.

Close liaison between the housing manager and his key personnel and contact personnel who are working with the families is essential. Neither group can delegate complete responsibility to the other. Housing authority personnel cannot be excluded or discriminated against by "professional" personnel who operate on the presumption that "case work" or "psychodynamics" is the cure-all for these families.

Housing managers are quite willing in most instances to go along with situations when social agencies are working with

chronic problem families. A classic case in the Boston area exemplifies this:

> A housing manager was willing to re-enter a family into a housing development after this family had, during a previous stay, caused $1500 worth of property damage and had caused other severe problems. The family was evicted at that time. The housing manager agreed to take the family in because an agency had been working with the family and now felt that it was capable of making more constructive use of the advantages offered in the housing development. The transformation in the family is short of miraculous. Three years of intensive work, while by no means solving all of their problems, has made it possible for this family to live in the housing development for almost a year now in a way that does not bear the slightest resemblance to their previous pattern of behavior.

6. A Method Of "Unit" Operation Within Housing Developments

It is desirable to have a special unit of personnel within the housing development to deal with the problems as they may arise. They are immediately available to assess with the housing manager whether a family giving trouble through non-payment of rent, or by creating trouble in the neighborhood, or

by defacing the property, is showing signs of being a chronic problem family.

Such a staff will be available immediately to contact families, assess the problem and the needs, and to begin implementing ways of meeting the crisis. Other agencies can be brought in as needed and planning can take place right within the housing development.

If the family is chronic problem and needs long-term follow-up, this is the point at which it can be arranged. An outside agency, better equipped to carry the long-range responsibility can take on the family as long as close liaison is maintained with the unit that operates within the housing development.

A very important factor in providing service to housing developments is the recognition of the need for 24-hour emergency coverage by professional personnel. Having such qualified personnel available around the clock to deal with emergencies often provides intervention in a family crisis which prevents it from becoming a full-blown catastrophe. These people often need to have their tensions relieved immediately and having someone available right away can make the difference between stopping an act of destruction or delinquency and the commission of the act.

7. General Considerations In Renewal Areas

Several additional issues are involved in relation to urban renewal for these families. Some of the available literature on chronic problem families discusses "experiments" in their

rehabilitation. Programs have been tried which have included the development of special housing units with personnel moving in to rehabilitate on a family-group basis. One experiment moved several families into a housing development with a central housekeeping or "mothering" service. This, unfortunately, avoids the need for "differential diagnosis" of individual families and for understanding the problems and capacities they have in taking advantage of the benefits of urban renewal.

In the matter of planning augmented services for these families, there are often enthusiastic proposals for recreation, religious, and social services for these families. This is a positive idea, but the problem arises from the inexorable fact that the personalities of many of these parents and children are such that they can only respond to these services in destructive ways.

This situation is analgous to dealing with juvenile delinquents. The idea of building more and better playgrounds or community centers fails because these people cannot utilize such services without intensive help. This is an integral part of their problem. The answer lies in recognizing that there must be people available to give family members active help in utilizing these services with understanding when they can not. Otherwise the programs by themselves will be unsuccessful in meeting the needs.

Adequately staffed nursery schools, recreation areas and centers for social activity are all vitally needed by these families. When people can take the time to help these families

use the facilities, the service becomes an integral part of the helping program.

In light of all the problems outlined, it is fruitless to talk about the "best" plan for these families as a group. This paper has emphasized the need for differential diagnoses and selective planning. An urban renewal program which permits flexibility in the movement of these families, commensurate with their capacity for integration into a neighborhood will enhance their chances for rehabilitation. The key is the development of a program which has the time and the latitude to carry out the "differential diagnosis" task which underlies any rehabilitation program.

Urban renewal offers the possibility for "selective" planning: 1) some families to remain in rehabilitation areas, 2) relocation of others to low-cost housing developments, 3) relocation of some to "temporary" housing, pending effect of treatment. This offers one of the greatest opportunities to detect, diagnose and treat the chronic problem family. Urban renewal authorities will need the most intensive cooperation of social welfare people to face and deal with this problem.

8. Time - A Key Factor In Planning

In reference to a key question about chronic problem families, present estimates indicate that if a family is worked with intensively and consistently over a period of 2 - 3 years, sufficient change for the better can take place, to the point where the family is much less of a pariah in the community. This does not mean that all

the problems are solved in this time, but it does mean that programs which are allowed to proceed with maximum latitude and minimum interference do provide hope for rehabilitation of chronic problem families.

Social Agency Contact

1. Methods Of Detecting Families In The Community

Throughout the urban renewal program, chronic problem families will continue to come to light. Until actual work is begun in an area, chronic problem families living there may not be known to any agency. If they are, they may not be considered as chronic problems because their contact with the given agency is not intensive enough to warrant such a designation. A large number of families will be known to a number of agencies. The problem here is one of obtaining and systematizing information that is available in agencies and service facilities.

Contact will be needed with most of the social agencies who service a particular area. The Department of Public Welfare, the Massachusetts Society for the Prevention of Cruelty to Children, and the general hospitals in the area will probably encompass the largest numbers of these families.

Further sources for detection are private agencies, e.g., Family Service Association, Jewish Family and Children's Service, Catholic Family Counseling Service, Boston Children's Services. Among the public agencies would be the various Department of Mental Health Facilities, e.g., state hospitals that service the area,

mental hygiene clinics, the Division of Legal Medicine. Other public agencies include the Department of Corrections, Massachusetts Youth Service Board, Division of Child Guardianship, boards of adult and juvenile parole, departments of adult and juvenile probation.

Included in the resources for detection are public and parochial schools, community centers, settlement houses, and churches. A further, important detection source are the local chapters of the various helping agencies, e.g., Salvation Army, Red Cross.

2. Some Techniques For Detection

Since we are considering here locating families who are known to various agencies and facilities, what will be required is a survey of these agencies. This is best carried out by an initial meeting with agency representatives to explain the purpose of the survey and to enlist their cooperation. They should be provided with a form which is simple and yet inclusive enough to permit agency personnel to identify chronic problem families in their case load.

Follow-up and consultation with the agencies will be needed to clarify some information and to speed up the reporting process. If more information is needed to check out a family's chronic problem status, the Social Service Exchange should be utilized.

3. Undetected Families

In regard to families who are not known to agencies, detection can begin at the public or parochial school, at the local

church, in the local police stations, in the bar rooms and grocery stores.

The Boston Edison and Boston Consolidated Gas Companies have records of families who have great difficulty in paying their bills and who go for long periods without gas or electricity. Landlords in the area are an excellent resource for detecting families who might not otherwise come to the attention of public authorities or private agencies. In reference to these private businesses, the approach must be extremely careful and sensitive so as not to imply "betrayal" or "squealing" on these families.

Two extremes need to be watched for in this respect. One may find the over-angry business man who has had a great deal of trouble with a family and may use this opportunity to over-indict them. The other extreme will be to protect them, either out of a basic loyalty to a similar class of people or out of a wish not to become involved.

Bar tenders are especially helpful in detecting families where there are hidden serious problems and where there has been no contact with agencies regarding such problems.

Guides and Directions

For

Rehabilitation Of The Chronic Problem Family

1. Summary Of The Present Problems

A rough estimate of the problem in Boston indicates that: 1) the Department of Public Welfare may be carrying 50% or more chronic problem families in its caseload, 2) 60 - 80% of the cases carried by the Massachusetts Society for the Prevention of Cruelty to Children, a state-wide child protective private agency, may well be chronic problem families, 3) Family Service Association, Catholic Family Counseling, Jewish Family and Children Services, and Boston Childrens Services may each have 25% of their cases consisting of these families, The figures reveal the fact that many of these families are being serviced by more than one agency. A large number of other agencies and institutions, in addition to those named above, are in contact with these families.

The present situation regarding chronic problem families in the Boston area, especially with respect to management and treatment, leaves much to be desired. Administrative personnel in major agencies are very concerned with both the financial burden and the heavy strain on personnel called for in the work with these families, so often with unsatisfactory results.

Most of the agencies involved either attempt to take total casework responsibility for a family or, because of functional limitations, try to provide segmented and fragmented services.

Neither extreme shows any measure of success. In the first instance, one worker becomes so immersed in the family's problems and overwhelmed by their needs, that there is little time or energy left for the major task of coordinating the services of other agencies, which are already in the case or may be needed as the case progresses.

In the second instance, the service provided because of functional limitations, usually deals with only one small part of the total problem, and thus provides only temporary help. Planning is usually disrupted because the rest of the family and the rest of the problems remain untreated. The problem of agency limitations and budget restrictions makes it almost impossible to obtain services when needed. The result is that a need may be perceived, but cannot be met except after a long and disheartening waiting period. The lack of trained personnel and the rather rapid turnover in personnel also contribute to the problems of providing services.

Not the least of the major problems is the fact that there are many different philosophies regarding methods of handling these families. These philosophies are often conflicting and confusing. Families who have more than one worker on their case will complain with some reality that they are much confused about the specific roles of these workers.

Another subtle but disruptive problem is the inability of agencies and facilities to trust each others' evaluations. This then leads to the need for repeated diagnosis each time a significant treatment move has to be made with a member of a chronic

problem family. This results in duplication and vast waste of manpower that is already strained to the utmost.

2. Guides And Directions For Rehabilitation

In planning for chronic problem families in connection with urban renewal, the first and most important step is for the social welfare community to decide who is going to care for these families and how. These are major policy issues; if they remain in the limbo of unsettled community business, it will be next to impossible to develop the rehabilitation programs that chronic problem families require.

The establishment of a new and separate agency to work directly with these families is not recommended 1) Because it has been shown how these families constantly run from one agency to another. The establishment of a new agency will do little to solve this problem, 2) Because of the nature and intensity of the problems, there is a tendency, to isolate these families. A new agency would simply become a "convenient dumping ground" and a way of getting rid of the problem, in many people's minds, 3) By and of itself such an agency would need to be so huge that it is impossible of accomplishment. It would duplicate, overlap, and only add to the already confusing issue of autonomy and definition of agency function.

3. Central Coordinating Agency Recommended

It is strongly recommended that the community face the need for the establishment of a central coordinating organization which will assume major responsibility for pulling together the diffuse

efforts that are currently being made on behalf of these families.

A coordinating organization can centralize all of the data on these families that is available from the various agencies.

A coordinating organization will be able to utilize the services of a large number of consultants in a far more efficient way than is currently available. A consultation service operating in this centralized way can give help on a much broader front. Various constellations of consultants should be included:

1. Psychiatric, psychological, casework.
2. Medical, nursing, dental, dietary.
3. Homemaking, budgeting, child care.
4. Social scientist, cultural anthropologists.
5. Educators, clergymen.
6. Vocational, job finding specialists.
7. Legal, insurance.
8. Alcoholism, crime control.

These represent many of the areas in which chronic problem families need special help. Any person carrying responsibility for a chronic problem family will welcome the consultation assistance of such personnel. Again, there is a need to emphasize the fact that the more qualitative effort that can be poured into these families, the better.

One of the most serious problems in working with these families has not been emphasized; this has to do with the tremendous pressure exerted upon workers. The intense, persistent and often

pathological demands made by these families can discourage and literally exhaust workers. If there is a central organization to which the workers can turn, which has available sustaining and supporting resources for dealing with the multiplicity of problems, this will reduce the workers' sense of isolation and increase their effectiveness.

A myth about confidentiality must be exploded. There is an exaggerated fear of sharing information about these families; this causes gross interference with communication. While it is obvious that reasonable confidentiality is required within ethical considerations, the fact remains that much information about these families is known in the community by virtue of their numerous contacts and difficulties.

It is much less a task of keeping "secret" information that is widely known, and much more a task of changing the nature of family functioning so that the reports become more positive. This "withholding of information" is often a form of "snobbery" to keep certain allied professionals out of cases for fear of what they will "do" to these families.

This confidentiality issue arises when workers, because of feelings about the families or concern that they may be called back into the case, will refuse to give information on the basis that it is "confidential." The truth is that when people are fully included, they work far more effectively and cooperate much more willingly in a total plan.

Another myth has to do with case sharing and supervision of cases. While it is important to maintain whatever supervisory structures exist in agencies dealing with these problems, it is also imperative to recognize that workers cannot carry these cases by themselves. Much sharing has to go on and more discussion of cases will take place than is ordinarily true of other kinds of cases. Workers and supervisors must be prepared to share information, both within their own agency and with other agencies.

Another very serious problem arises when workers in a general type of agency are assigned a "special" caseload of chronic problem families. They often work in isolation and become quickly depressed and discouraged.

A central coordinating organization, through use of a core of staff people and consultants, can do the kind of extensive evaluation, diagnosis, management, and treatment programming that cannot be duplicated by individual agencies or facilities.

It has often been pointed out that the current method of providing services to chronic problem families is highly fragmented and tends to split the families. Coordination of efforts will bring the family into a "whole" pattern with a much more objective over-view. This will provide feed-back to the workers, will systematize planning, and will reduce the inconsistency of service stemming from the families' attempts to play off agencies.

Two crucial functions of such a coordinating group are training and research. Specialized training is required for personnel dealing with chronic problem families. This training

should be available to everyone involved in working with these families, irrespective of agency or professional background. The training program should be aimed at integrating the contributions from the many disciplines which need to help with these families, e.g., individual psychodynamics, group dynamics relating to families, community organization, social and cultural factors, basic medical knowledge, casework techniques, budgeting, etc.

Such a training program should be planned as part of the work week of personnel involved in working with these families. Such a training program argues against the idea that caseworkers with generic training or probation officers with special skills in handling children should be able to work with these families. The present generic training in social work and training in probation work cannot keep up with the many findings regarding the special techniques needed with these families. While there are many things we do not know about these families, there are many things we do know that need to be transmitted to working personnel.

Research at several levels is obviously needed and can be forthcoming in a systematic way from such a central organization. The inclusion of the different consultant groups can enrich the teaching and research opportunities.

3. Self-Examination

A "self-examination" process of all agencies and facilities dealing with chronic problem families is needed. Historically,

agencies, clinics, settlement houses, and other facilities made valiant attempts to deal with these kinds of families. But as their functions were broadened to include other populations and they became "professionalized", these families were shunted aside. They fitted less and less into the new concepts of functioning that have evolved, especially in many private agencies. Public agencies not specifically designated to work with these families have done less and less planning to meet their needs.

Agencies that accept any responsibility for these families, either voluntarily or by legal requirement, must re-assess and re-adapt their present methods of functioning. For example, Public Welfare budgets may need special revisions. Job-finding agencies may need to give more support to helping fathers and children obtain and hold jobs. Schools may have to assign special staff and home tutors for many children in these families. Community centers may require special staffs and special programming for these parents and children. General casework agencies will need to accept long-range commitments for care and treatment of these families. Mental hospitals will need to modify commitment procedures to care for borderline psychotic parents and children on a temporary hospitalization basis.

Workers with chronic problem families will need access to the full resources of the community and freedom to call upon such resources as required.

4. Staffing and Caseload

Agencies should not be required to carry too large a number of chronic problem families in their caseload.

If possible, agency workers should be given a mixed caseload - with no more than 12-to-15 chronic problem families. Two to five "other" less severe cases can be carried in addition, to reduce the sense of frustration and tension these families provoke in workers.

Workers with these families should be comfortable in dealing with problems of poverty, neglect and anti-social behavior. They should be non-judgemental, mature and not given to extreme compulsivity. They must understand the role of authority and use it therapeutically.

These are some of the qualifications for workers, but they point up the need for careful selection of workers for these families.

5. Summary

If more than one agency or facility is involved with a family, planning meetings should be held and one person should be designated "anchor" person, the main contact and coordinator working with the family. This will reduce duplication and cross-planning. Ideally, this person should have sufficient special training to carry out the plans which are set up in the diagnostic and evaluation stages.

The concept of a coordinating organization, the concept of agency cooperation, the concept of community mobilization for action to benefit these families, all hinge on what is an over-simplified but irrefutable fact: as long as these families and their needs are kept in the forefront of our thinking, we are in a better

position to deal with problems of "vested interest", of "autonomy", and of "communication and cooperation".

The medical world has adapted its techniques to meet the nature of the illness. An appendectomy is performed at its location, rather than another part of the body which might be more desirable for surgery. The same basic rule applies here and can never be forgotten. Agreements must be reached by the community at high levels to determine 1) who these families are, 2) the responsibility of the community to them, 3) the methods and plans for dealing with them, 4) the delegation of responsibility for implementing these plans with maximum efficiency, and 5) the follow-through necessary to guarantee that these families will not be abandoned or shunted aside in the process of community planning.

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